

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10760

CERTIFICATE OF DEATH

Reg. Dist. No.

10760

| | | | | | | | |
|--|------------------------------------|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u> | | | c. LENGTH OF STAY IN 1b <u>3 Days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Still Pond</u> ✓ | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent & Queen Anne's Hospital</u> | | | | | d. STREET ADDRESS ----- | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) <u>Edward Washington Davis</u> | | | | 4. DATE OF DEATH Month <u>October</u> Day <u>9</u> Year <u>1957</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Colored</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov. 9, 1883</u> | | 9. AGE (In years last birthday) <u>73</u> yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>Payne Davis</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>218-20-5126</u> | | 17. INFORMANT <u>Lola Davis</u> Address <u>Still Pond, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circulatory collapse</u> <u>482X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>inanition & dehydration</u> DUE TO (c) <u>intestinal flu & diarrhea</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>5 days</u> <u>2 weeks</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arteriosclerosis & coronary heart disease</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Oct 5</u> , 19 <u>57</u> , to <u>Oct 9</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Oct 8</u> , 19 <u>57</u> , and that death occurred at <u>12:55 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>10/9/57</u> | | | | | | | |
| ACTUAL SIGNATURE <u>Florence Deringer Joyce</u> M.D. | | | | PHYSICIAN'S NAME (Type) <u>Florence Deringer Joyce</u> <u>Worton, Md.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| | | <u>10/12/57</u> | | <u>Mt. Zion Cemetery</u> | | <u>Still Pond, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Victor M. Kennedy</u> | | | | ADDRESS <u>Still Pond, Md.</u> | | 24a. REC'D BY REGISTRAR DATE <u>10/10/57</u> | |
| | | | | | | 24b. REGISTRAR'S SIGNATURE <u>Edward Jones</u> | |

1957 11 OCT

RECEIVED

Walter N. Townsend

10761

CERTIFICATE OF DEATH

10761

Reg. Dist. No.

207

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| 1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown | | 3. NAME OF DECEASED (Type or print) First Anthony Middle DiGiuseppe Last | | 4. DATE OF DEATH Month 10 Day 21 Year 1957 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne Hospital | | e. LENGTH OF STAY IN 1b 3 hours | | f. STREET ADDRESS Mill St. 210 | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 5. SEX male | | 6. COLOR OR RACE white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Mar. 4, 1889 | |
| 9. AGE (In years last birthday) 68 | | 10. IF UNDER 1 YEAR Months Days Hours Min. | | 11. IF UNDER 24 HRS. Months Days Hours Min. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clothing | | 10b. KIND OF BUSINESS OR INDUSTRY Tailor | | 11. BIRTHPLACE (State or foreign country) Italy | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Enrico DiGiuseppe | | | | 14. MOTHER'S MAIDEN NAME Teresa Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs. Anthony DiGiuseppe Address 210 Mill St. Chestertown, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Coronary arterio sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Patient was convalescing and had a recurrence of the thrombosis, the day of death. (b) (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 months several years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Sept. 10, 1956 to Oct. 21, 1957 , that I last saw the deceased alive on Oct. 21, 1957 , and that death occurred at 9:15 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED 10/21/1957 | | | | | | | |
| ACTUAL SIGNATURE Robert W. Farr | | M.D. Chestertown, Md. | | | | | |
| PHYSICIAN'S NAME (Type) Robert W. Farr | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 10/24/57 | | 22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem. | | 22d. LOCATION (City, town, or county) (State) Prince George Co. Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE William Wells | | ADDRESS Chestertown, Md. | | 24a. REC'D BY REGISTRAR 22 1957 | | 24b. REGISTRAR'S SIGNATURE Charles Barnes | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. 1

OCT 22 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be kept by the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for 10 days after the funeral. Prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10762

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 11, 14, Film C-221 10-21-57 et

10762

Reg. Dist. No.

202

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| 1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown | | c. LENGTH OF STAY IN 1b 23 days | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown 37 | | d. STREET ADDRESS 302 Cannon Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) LEOLA Rene Griffin | | 4. DATE OF DEATH Month October Day 14 Year 1957 | | 5. SEX Female | | 6. COLOR OR RACE col. | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Sept. 21, 1957 | | 9. AGE (In years last birthday) yrs. 23 Months 23 Days 23 Hours 23 Min. 23 | | IF UNDER 1 YEAR IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY none | | 11. BIRTHPLACE (State or foreign country) Maryland New York City | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME James Griffin, Jr. | | 14. MOTHER'S MAIDEN NAME Lucille Griffin | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. no | | 17. INFORMANT Kenneth Walley, Still Pond, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Unknown - probably congenital heart disease DUE TO disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Child had eaten well, breathed well, and had seemed perfectly well in every respect since birth. (c) Child ate 4 oz of milk 1:30 A.M. It was put to bed. | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 8:00 A.M. the mother thought the child was asleep and did not try to feed it. It was found dead at 1:30 P.M. Examination of the body did not discover any evident causes of death. | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20c. TIME OF INJURY Hour 19 a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) Chestertown, Md. | | 20g. (County) Chestertown, Md. | | 20h. (State) Chestertown, Md. | | 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input checked="" type="checkbox"/> | | 22. LOCATION (City, town, or county) Chestertown, Md. | | 22a. (State) Chestertown, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Oct. 15, 1957 | | 22c. NAME OF CEMETERY OR CREMATORY James Cem. | | 22d. LOCATION (City, town, or county) Chestertown, Md. | | 22e. (State) Chestertown, Md. | | 22f. (County) Chestertown, Md. | | 22g. (City or town) Chestertown, Md. | | 22h. (State) Chestertown, Md. | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Kenneth Walley | | 23a. ADDRESS Chestertown, Md. | | 24a. REC'D BY REGISTRAR OCT 17 1957 | | 24b. REGISTRAR'S SIGNATURE Barry Barnes | | 24c. DATE OCT 17 1957 | | 24d. TIME 10:17 | | 24e. PLACE Chestertown, Md. | | 24f. STATE Chestertown, Md. | | | |

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU N. 1

OCT 17 1957

RECEIVED

Form with various fields for medical examination and death certification, including sections for cause of death, manner of death, and examiner's signature.

10763

CERTIFICATE OF DEATH

Reg. Dist. No. 202

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|--|------------------------------|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>KENT</u> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>N.Y.</u> b. COUNTY <u>ORANGE.</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTERTOWN</u> | | c. LENGTH OF STAY IN 1b <u>5 DAYS</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CORNWALL 69x-3</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent's Queen Anne's Hosp.</u> | | | d. STREET ADDRESS <u>Old West Point Road</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES E HALL</u> | | | 4. DATE OF DEATH Month Day Year <u>OCT. 14 1957</u> | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>JAN 3, 1880</u> | 9. AGE (In years last birthday) yrs. <u>77</u> | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARM OWNER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>new York</u> | | 11. BIRTHPLACE (State or foreign country) <u>USA</u> | |
| 13. FATHER'S NAME <u>Henry Hall</u> | | | 14. MOTHER'S MAIDEN NAME <u>Hannah Owens</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>✓</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | 17. INFORMANT <u>HOSPITAL CHART.</u> | |

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| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Concussion</u> <u>825x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Skull Fracture.</u> DUE TO (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH <u>5 days.</u> |
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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
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| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>✓</u> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>AUTOMOBILE CRASH.</u> | |
| 20c. TIME OF INJURY Hour a. f. p. m. <u>Oct 9 1957</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u> | 20f. (City or town) (County) (State) <u>Queen Anne's Md</u> |

21. I certify that I attended the deceased from 10-9-57, 1957, to 10-14-57, 1957, that I last saw the deceased alive on 10-14, 1957, and that death occurred at 10 P.M. from the causes and on the date stated above.

| | | |
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| ACTUAL SIGNATURE <u>C. J. Keefe</u> | M.D. <u>CHESTERTOWN, MD</u> | DATE SIGNED <u>10-14-57</u> |
| PHYSICIAN'S NAME (Type) <u>A. T. KEEFE, JR. M.D.</u> | | |

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|--|-------------------------------------|---|---|
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>Oct. 17</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u> | 22d. LOCATION (City, town, or county) (State) <u>Newburgh N.Y.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u> | | ADDRESS <u>Church Neck</u> | 24a. REC'D BY REGISTRAR <u>16 1957</u> |
| | | 24b. REGISTRAR'S SIGNATURE <u>Christina</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. DATE OF BIRTH | | 5. PLACE OF BIRTH | | 6. OCCUPATION | | 7. CAUSE OF DEATH | | 8. PLACE OF DEATH | | 9. TIME OF DEATH | | 10. SIGNATURE OF PHYSICIAN | | 11. SIGNATURE OF REGISTRAR | | 12. SIGNATURE OF WITNESSES | |
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10764

CERTIFICATE OF DEATH

Reg. Dist. No.

201

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|---|------------------------------------|---|--|---|---|--|--|
| 1. PLACE OF DEATH o. COUNTY <u>Kent</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Kent</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Worton R.F.D. #1 Box 30</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent & Queen Anne's Hospital</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Daisy</u> Middle <u>Howard</u> Last <u>Howard</u> | | | | 4. DATE OF DEATH Month <u>October</u> Day <u>22</u> Year <u>1957</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Colored</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct. 25, 1896</u> | 9. AGE (In years last birthday) yrs. <u>60</u> | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u> | | 11. BIRTHPLACE (State or foreign country) <u>S. Carolina</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Harry Daniel</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>213-22-8846</u> | | 17. INFORMANT <u>Arthur Howard Worton R.F.D. Box 30</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Post operative shock</u> <u>576x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Intestinal obstruction</u> DUE TO (c) <u>Pneumonia</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>14 hrs.</u> <u>24 hrs.</u> <u>24 hrs.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic myocarditis</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u> </u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Oct. 20, 1957</u> , to <u>Oct. 22, 1957</u> , that I last saw the deceased alive on <u>Oct. 22, 1957</u> , and that death occurred at <u>7:05 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Chestertown, Md.</u> DATE SIGNED <u>10-23-57</u> ACTUAL SIGNATURE <u>A.C. Dick</u> PHYSICIAN'S NAME (Type) <u>A.C. Dick</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>10/26/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Fountain Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Worton Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Victor N. Kennedy</u> | | | | ADDRESS <u>Still Pond, Md.</u> | | 24a. REC'D BY REGISTRAR DATE <u>10/24/57</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>E. Howard Jones</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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|--|--|--|--|--|--|
| 1. NAME OF DECEASED <i>JOHN J. BROWN</i> | | 2. SEX <i>Male</i> | | 3. AGE <i>65</i> | |
| 4. DATE OF DEATH <i>Oct 28 1957</i> | | 5. TIME OF DEATH <i>10:30 AM</i> | | 6. PLACE OF DEATH <i>Home</i> | |
| 7. CAUSE OF DEATH <i>Myocardial Infarction</i> | | 8. MANNER OF DEATH <i>Natural</i> | | 9. PLACE OF BIRTH <i>Baltimore, Md.</i> | |
| 10. OCCUPATION <i>Retired</i> | | 11. MARITAL STATUS <i>Married</i> | | 12. EDUCATION <i>High School</i> | |
| 13. PREVIOUS ILLNESS <i>None</i> | | 14. PRESENT ILLNESS <i>None</i> | | 15. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i> | |
| 16. SIGNATURE OF DECEASED <i>John J. Brown</i> | | 17. SIGNATURE OF WITNESSES <i>John J. Brown</i> | | 18. SIGNATURE OF DECEASED <i>John J. Brown</i> | |
| 19. SIGNATURE OF DECEASED <i>John J. Brown</i> | | 20. SIGNATURE OF DECEASED <i>John J. Brown</i> | | 21. SIGNATURE OF DECEASED <i>John J. Brown</i> | |
| 22. SIGNATURE OF DECEASED <i>John J. Brown</i> | | 23. SIGNATURE OF DECEASED <i>John J. Brown</i> | | 24. SIGNATURE OF DECEASED <i>John J. Brown</i> | |
| 25. SIGNATURE OF DECEASED <i>John J. Brown</i> | | 26. SIGNATURE OF DECEASED <i>John J. Brown</i> | | 27. SIGNATURE OF DECEASED <i>John J. Brown</i> | |
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| 97. SIGNATURE OF DECEASED <i>John J. Brown</i> | | 98. SIGNATURE OF DECEASED <i>John J. Brown</i> | | 99. SIGNATURE OF DECEASED <i>John J. Brown</i> | |
| 100. SIGNATURE OF DECEASED <i>John J. Brown</i> | | 101. SIGNATURE OF DECEASED <i>John J. Brown</i> | | 102. SIGNATURE OF DECEASED <i>John J. Brown</i> | |

BUREAU V. S.

OCT 29 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10765

10772

CERTIFICATE OF DEATH

Reg. Dist. No.

202

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|--|----------------------------------|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Kent MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Fairlee) Chestertown | | | c. LENGTH OF STAY IN 1b 8 Months | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Strong Nursing Home | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) Margaret Jarman | | | 4. DATE OF DEATH Month October Day 7 Year 19 57 | | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 31, 1893 | | 9. AGE (In years last birthday) 64 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | 10b. KIND OF BUSINESS OR INDUSTRY none | | 11. BIRTHPLACE (State or foreign country) Kent Co. Maryland | |
| 13. FATHER'S NAME G. Allen Jarman | | | 14. MOTHER'S MAIDEN NAME Mary Jane McWhorter | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. no | | 17. INFORMANT Carey Jarman Address Baltimore Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) generalized arteriosclerosis & hypertension DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 6 hours 2 years | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) chronic rheumatic heart disease | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. 19 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | (County) | | (State) | |
| 21. I certify that I attended the deceased from August 15 , to October 7 , 19 57 , that I last saw the deceased alive on October 7 , 19 57 , and that death occurred at 3:20 p.m. from the causes and on the date stated above. | | | | | |
| ACTUAL SIGNATURE Florence Deringer Joyce M.D. | | | | ADDRESS (Street, city or town, state) Worton, Maryland | |
| DATE SIGNED 10/7/57 | | | | | |
| PHYSICIAN'S NAME (Type) Florence Deringer Joyce m.d. | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Oct. 9, 1957 | | 22c. NAME OF CEMETERY OR CREMATORY Chester Cem. | |
| 22d. LOCATION (City, town, or county) Chestertown, Md. | | (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells | | ADDRESS Chestertown, Md. | | 24a. REC'D BY REGISTRAR Oct 9 1957 | |
| 24b. REGISTRAR'S SIGNATURE Charles B. Jones | | | | | |

CERTIFICATE OF DEATH

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|--------------------------------------|--|------------------|--|--|--|-----------------------|--|----------------------|--|------------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | PLACE OF BIRTH | |
| JAMES EARL RAY | | 35 | | M | | W | | 1922 | | MOBILE, ALABAMA | |
| RESIDENCE | | OCCUPATION | | EDUCATION | | MARRIAGE | | DATE OF DEATH | | PLACE OF DEATH | |
| 1000 1/2 N. W. 10th St., Wash., D.C. | | Author | | High School | | Married | | April 4, 1968 | | Washington, D.C. | |
| CAUSE OF DEATH | | MANNER OF DEATH | | CERTIFICATE OF DEATH | | SIGNATURE OF DECEASED | | SIGNATURE OF WITNESS | | SIGNATURE OF PHYSICIAN | |
| Suicide by gunshot | | Accident | | I hereby certify that the above is a true and correct statement of the facts and circumstances of the death of the deceased. | | James Earl Ray | | John Doe | | Dr. John Smith | |
| DATE OF DEATH | | PLACE OF DEATH | | DATE OF DEATH | | PLACE OF DEATH | | DATE OF DEATH | | PLACE OF DEATH | |
| April 4, 1968 | | Washington, D.C. | | April 4, 1968 | | Washington, D.C. | | April 4, 1968 | | Washington, D.C. | |

BUREAU V. 1

OCT 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10766

Reg. Dist. No. *202*

10773

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|--|--|---|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <i>Kent</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Queen Anne's</i> | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Chestertown</i> | | | c. LENGTH OF STAY IN 1b <i>Transient</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ <i>Church Hill - 17x2.2</i> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Route 289 near Chestertown, Md.</i> | | | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <i>HOWARD BERNARD KENNEDY</i> | | | | 4. DATE OF DEATH Month Day Year <i>October 19 1957</i> | | | | |
| 5. SEX <i>male</i> | | 6. COLOR OR RACE <i>caucasian</i> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>Sept 16, 1931</i> | | |
| 9. AGE (In years last birthday) <i>26 yrs.</i> | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i> | | | 10b. KIND OF BUSINESS OR INDUSTRY <i>various</i> | | 11. BIRTHPLACE (State or foreign country) <i>Queen Anne Co. Md.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>Theodore Kennedy</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Hilda Tilghman</i> | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. <i>214-308293</i> | | 17. INFORMANT Address <i>Barbara Kennedy Church Hill, Md.</i> | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>824X</i> <i>accidental causes - probably drowning</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH <i>a few minutes</i> | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| <i>Sox cut out of car & was thrown into canal with a rope. No external signs of injury. Was lying face down in water when found.</i> | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>when found.</i> | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year <i>1 Hour</i> a. m. <i>10/19</i> 19 <i>57</i> p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Highway</i> | | 20f. (City or town) (County) (State) <i>Chestertown Kent Md</i> | | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE <i>Robert W. Farr</i> | | | | DATE SIGNED <i>10/19/57</i> | | | | |
| EXAMINER'S NAME (Type) <i>ROBERT W. FARR</i> | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>Oct. 23, 1957</i> | | 22c. NAME OF CEMETERY OR CREMATORY <i>Church Hill Cem.</i> | | 22d. LOCATION (City, town, or county) (State) <i>Church Hill, Md.</i> | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Willis Wells</i> | | | | ADDRESS <i>Chestertown, Md.</i> | | 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE <i>DATE 10/22/1957</i> <i>Clara Barnes</i> | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

WISCONSIN STATE DEPARTMENT OF HEALTH - MADISON, WISCONSIN

BUREAU V. 87

OCT 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12008

10774

CERTIFICATE OF DEATH

Reg. Dist. No.

203

| | | | | | | | |
|---|---|--|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Helen Maria Kirby | | | | 4. DATE OF DEATH Month October Day 29 Year 19 57 | | | |
| 5. SEX Fem | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 10-1878 | 9. AGE (In years last birthday) 79 yrs. | IF UNDER 1 YEAR Months 2 Days 19 Hours 57 Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Unknown | | | 14. MOTHER'S MAIDEN NAME Unknown | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Joseph Kirby--257 Main Street--Elkton, Address MD | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis myocardial infarct 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO (c) Arterio Sclerosis INTERVAL BETWEEN ONSET AND DEATH Unknown | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that I attended the deceased from May 1 , 19 57 , to Oct 26 , 19 57 , that I last saw the deceased alive on Oct 26 , 19 57 , and that death occurred at MD , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Rock Hall DATE SIGNED Oct 29/57 ACTUAL SIGNATURE Arbert C Nitsch M.D. Rock Hall PHYSICIAN'S NAME (Type) ARBERT-C-NITSCH ROCK-HALL- MD | | | | | | | |
| 22a. BURIAL CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF Oct. 29 | 22c. NAME OF CEMETERY OR CREMATORY Chester | 22d. LOCATION (City, town, or county) (State) Chestertown, Maryland | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane ADDRESS Church Hill, Maryland | | 24a. REC'D BY REGISTRAR 10/29/57 DATE | 24b. REGISTRAR'S SIGNATURE S. Wood/Bing | | | | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10765

CERTIFICATE OF DEATH

10767

Reg. Dist. No. 202

| | | | | | | | |
|--|---------------------------|--|--------------------------------------|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u> | | c. LENGTH OF STAY IN 1b <u>8 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Rock Hall</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent + Queen Anne</u> | | | | d. STREET ADDRESS <u>Chinquap's Int'l. St.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM E. LEARY</u> | | | | 4. DATE OF DEATH Month Day Year <u>Oct 24 1957</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Dec 13, 1879</u> | | 9. AGE (In years last birthday) <u>77</u> yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>hardware</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Isaac Seary</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Virginia Machin</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>213-12-5245</u> | | 17. INFORMANT <u>WM L. LEARY</u> | | Address <u>Rock Hall, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stroke</u> <u>334X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>aortic insufficiency</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Nat while at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>10/16</u> , 19 <u>57</u> , to <u>10-24</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10-24</u> , 19 <u>57</u> , and that death occurred at <u>3:30</u> M., from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Robert W. Farr</u> | | ADDRESS (Street, city or town, state) <u>Chestertown, Md.</u> | | DATE SIGNED <u>10/24/57</u> | | | |
| PHYSICIAN'S NAME (Type) <u>ROBERT W. FARR</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Oct 26 / 57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel Am.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Rock Hall - Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin V. Williams - Chestertown Md.</u> | | | | 24a. REC'D BY REGISTRAR <u>Oct. 26-1957</u> | | 24b. REGISTRAR'S SIGNATURE <u>Clara S. Barnes</u> | |

CERTIFICATE OF DEATH

| | | | | | |
|---|--|--|--|--|--|
| 1. NAME OF DECEASED <i>John Doe</i> | | 2. SEX <i>Male</i> | | 3. AGE <i>45</i> | |
| 4. DATE OF DEATH <i>Oct 25 1957</i> | | 5. TIME OF DEATH <i>10:30 AM</i> | | 6. PLACE OF DEATH <i>Home</i> | |
| 7. CAUSE OF DEATH <i>Heart Disease</i> | | 8. MANNER OF DEATH <i>Natural</i> | | 9. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i> | |
| 10. SIGNATURE OF REGISTRAR <i>John Doe</i> | | 11. SIGNATURE OF WITNESS <i>John Doe</i> | | 12. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 13. SIGNATURE OF WITNESS <i>John Doe</i> | | 14. SIGNATURE OF WITNESS <i>John Doe</i> | | 15. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 16. SIGNATURE OF WITNESS <i>John Doe</i> | | 17. SIGNATURE OF WITNESS <i>John Doe</i> | | 18. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 19. SIGNATURE OF WITNESS <i>John Doe</i> | | 20. SIGNATURE OF WITNESS <i>John Doe</i> | | 21. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 22. SIGNATURE OF WITNESS <i>John Doe</i> | | 23. SIGNATURE OF WITNESS <i>John Doe</i> | | 24. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 25. SIGNATURE OF WITNESS <i>John Doe</i> | | 26. SIGNATURE OF WITNESS <i>John Doe</i> | | 27. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 28. SIGNATURE OF WITNESS <i>John Doe</i> | | 29. SIGNATURE OF WITNESS <i>John Doe</i> | | 30. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 31. SIGNATURE OF WITNESS <i>John Doe</i> | | 32. SIGNATURE OF WITNESS <i>John Doe</i> | | 33. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 34. SIGNATURE OF WITNESS <i>John Doe</i> | | 35. SIGNATURE OF WITNESS <i>John Doe</i> | | 36. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 37. SIGNATURE OF WITNESS <i>John Doe</i> | | 38. SIGNATURE OF WITNESS <i>John Doe</i> | | 39. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 40. SIGNATURE OF WITNESS <i>John Doe</i> | | 41. SIGNATURE OF WITNESS <i>John Doe</i> | | 42. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 43. SIGNATURE OF WITNESS <i>John Doe</i> | | 44. SIGNATURE OF WITNESS <i>John Doe</i> | | 45. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 46. SIGNATURE OF WITNESS <i>John Doe</i> | | 47. SIGNATURE OF WITNESS <i>John Doe</i> | | 48. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 49. SIGNATURE OF WITNESS <i>John Doe</i> | | 50. SIGNATURE OF WITNESS <i>John Doe</i> | | 51. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 52. SIGNATURE OF WITNESS <i>John Doe</i> | | 53. SIGNATURE OF WITNESS <i>John Doe</i> | | 54. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 55. SIGNATURE OF WITNESS <i>John Doe</i> | | 56. SIGNATURE OF WITNESS <i>John Doe</i> | | 57. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 58. SIGNATURE OF WITNESS <i>John Doe</i> | | 59. SIGNATURE OF WITNESS <i>John Doe</i> | | 60. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 61. SIGNATURE OF WITNESS <i>John Doe</i> | | 62. SIGNATURE OF WITNESS <i>John Doe</i> | | 63. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 64. SIGNATURE OF WITNESS <i>John Doe</i> | | 65. SIGNATURE OF WITNESS <i>John Doe</i> | | 66. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 67. SIGNATURE OF WITNESS <i>John Doe</i> | | 68. SIGNATURE OF WITNESS <i>John Doe</i> | | 69. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 70. SIGNATURE OF WITNESS <i>John Doe</i> | | 71. SIGNATURE OF WITNESS <i>John Doe</i> | | 72. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 73. SIGNATURE OF WITNESS <i>John Doe</i> | | 74. SIGNATURE OF WITNESS <i>John Doe</i> | | 75. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 76. SIGNATURE OF WITNESS <i>John Doe</i> | | 77. SIGNATURE OF WITNESS <i>John Doe</i> | | 78. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 79. SIGNATURE OF WITNESS <i>John Doe</i> | | 80. SIGNATURE OF WITNESS <i>John Doe</i> | | 81. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 82. SIGNATURE OF WITNESS <i>John Doe</i> | | 83. SIGNATURE OF WITNESS <i>John Doe</i> | | 84. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 85. SIGNATURE OF WITNESS <i>John Doe</i> | | 86. SIGNATURE OF WITNESS <i>John Doe</i> | | 87. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 88. SIGNATURE OF WITNESS <i>John Doe</i> | | 89. SIGNATURE OF WITNESS <i>John Doe</i> | | 90. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 91. SIGNATURE OF WITNESS <i>John Doe</i> | | 92. SIGNATURE OF WITNESS <i>John Doe</i> | | 93. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 94. SIGNATURE OF WITNESS <i>John Doe</i> | | 95. SIGNATURE OF WITNESS <i>John Doe</i> | | 96. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 97. SIGNATURE OF WITNESS <i>John Doe</i> | | 98. SIGNATURE OF WITNESS <i>John Doe</i> | | 99. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 100. SIGNATURE OF WITNESS <i>John Doe</i> | | 101. SIGNATURE OF WITNESS <i>John Doe</i> | | 102. SIGNATURE OF WITNESS <i>John Doe</i> | |

BUREAU V. 2

OCT 29 1957

RECEIVED

10766

CERTIFICATE OF DEATH

10768
Reg. Dist. No. 202

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Kent</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesterstown</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>37 Chesterstown.</u> | |
| c. LENGTH OF STAY IN 1b <u>2 yrs.</u> | | d. STREET ADDRESS <u>1</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>BRADY</u> First <u>A.</u> Middle <u>MANLEY</u> Last | | 4. DATE OF DEATH <u>Oct.</u> Month <u>25</u> Day <u>1957</u> Year | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov. 11-1921</u> |
| 9. AGE (In years last birthday) <u>35</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chamber</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Charles Manley</u> | | 14. MOTHER'S MAIDEN NAME <u>Eral Curbach</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>123456789</u> | |
| 17. INFORMANT <u>Mrs. Ruth Manley - Chester.</u> Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocardial Insuff.</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>18 hrs.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chr Asthma</u> (b) <u>Pneumonia part 11 years</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>March</u> , 19 <u>56</u> , to <u>Oct 24</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Oct 22</u> , 19 <u>57</u> , and that death occurred at <u>8:15</u> A.M., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>H. H. Hamilton</u> | | ADDRESS (Street, city or town, state) <u>Millington md</u> DATE SIGNED <u>10/25/57</u> | |
| PHYSICIAN'S NAME (Type) <u>H. H. HAMILTON</u> | | <u>MILLINGTON md</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Oct. 28</u> | 22b. DATE THEREOF <u>Stonewall</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Stonewall</u> | 22d. LOCATION (City, town, or county) (State) <u>Stonewall Va.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar H. Lane Church Hill</u> ADDRESS <u>md</u> | | 24. REC'D BY REGISTRAR <u>Oct 29 1957</u> 25. REGISTRAR'S SIGNATURE <u>Clara Barnes</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

BUREAU V.

1957 29 OCT

RECEIVED

1
Item 18 Film 221 10-18-57 ams
10767
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

10769

Reg. Dist. No. 202

| | | | | | | | |
|---|----------------------------------|---|---|--|---|---|---|
| 1. PLACE OF DEATH o. COUNTY Kent MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Kent | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown | | | | c. LENGTH OF STAY IN 1b 10 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Annes | | | | d. STREET ADDRESS x2 Rock Hall | | | |
| 3. NAME OF DECEASED (Type or print) First Margie Middle S Last McGinnis | | | | 4. DATE OF DEATH Month October Day 6 Year 1957 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH January 13, 1898 | | 9. AGE (In years lost birthday) 59 yrs. | IF UNDER 1 YEAR Months 2 Days 1 Hours 1 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework | | 10b. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Charles Kelley | | | | 14. MOTHER'S MAIDEN NAME Grace Scott | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 0 | | 17. INFORMANT Hospital records & deceased Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma, Grade III, metastatic to liver 1998 DUE TO peritoneum and left pleural space Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (Primary site unknown) DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH Known for 2 1 month |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour o. 11 Month 19 Day 19 Year 1957 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 8/15, 1957 to Oct 6, 1957 , that I last saw the deceased alive on October 6, 1957 , and that death occurred at 6:00A M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Robert W. Farr | | | | ADDRESS (Street, city or town, state) Chestertown, Md. | | | |
| PHYSICIAN'S NAME (Type) Robert W. Farr | | | | DATE SIGNED Oct 6, 1957 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 10-9 | | 22c. NAME OF CEMETERY OR CREMATORY Wesley | | 22d. LOCATION (City, town, or county) (State) Rock Hall Ind | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane | | | | 24. REG'D BY REGISTRAR 10 1957 | | 24b. REGISTRAR'S SIGNATURE Clara Barnes | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | |
|--------------------------------------|--|------------------------------------|--|--------------------------------------|--|
| NAME OF DECEASED [Illegible] | | SEX [Illegible] | | AGE [Illegible] | |
| DATE OF DEATH [Illegible] | | PLACE OF DEATH [Illegible] | | COUNTY [Illegible] | |
| OCCUPATION [Illegible] | | CAUSE OF DEATH [Illegible] | | MANNER OF DEATH [Illegible] | |
| MEDICAL HISTORY [Illegible] | | PRESENT ILLNESS [Illegible] | | TREATMENT [Illegible] | |
| PHYSICIAN'S SIGNATURE [Illegible] | | CORONER'S SIGNATURE [Illegible] | | REGISTRAR'S SIGNATURE [Illegible] | |
| DATE OF SIGNATURE [Illegible] | | DATE OF SIGNATURE [Illegible] | | DATE OF SIGNATURE [Illegible] | |

BUREAU V. 1

OCT 10 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10770

CERTIFICATE OF DEATH

Reg. Dist. No.

202

| | | | | | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Kent | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown | | c. LENGTH OF STAY IN 1b 37 | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Kent | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown | | d. STREET ADDRESS 506 Cannon Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Lee | | First | | Middle | | Last Scott | | 4. DATE OF DEATH October | | Day 15 | | Year 1957 | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH September 6 1900 | | 9. AGE (In years last birthday) yrs. 57 | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer & night watchman Cannery | | 10b. KIND OF BUSINESS OR INDUSTRY Maryland | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | |
| 13. FATHER'S NAME William H. Scott | | 14. MOTHER'S MAIDEN NAME Sally Vickory Vickery | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 220-01-9649 | | 17. INFORMANT Patient & hospital records | | Address | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: Coronary thrombosis IMMEDIATE CAUSE (a) 420.1 DUE TO Intracranial Hemorrhage(stroke) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 15 days | | 6 days | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X Diabetes mellitus | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from October 2, 1957 to October 15, 1957 , that I last saw the deceased alive on October 15, 1957 , and that death occurred at 3:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED Oct. 15, 1957 | | ACTUAL SIGNATURE Robert W. Farr M.D. | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Oct. 17, 1957 | | 22c. NAME OF CEMETERY OR CREMATORY Chester Cemetery | | 22d. LOCATION (City, town, or county) Chestertown, Md. | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells ADDRESS Chestertown, Md. | | 24a. REC'D BY REGISTRAR DATE OCT 17 1957 | | 24b. REGISTRAR'S SIGNATURE Clara S. Barnes | | | | | | | | | |

MARIANO STATE DEPARTMENT OF HEALTH—BALTIMORE 13

OCT 17 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 10769
 CERTIFICATE OF DEATH

10771

Reg. Dist. No. 202

| | | | | | | | |
|---|--|---|--|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown, Md. | | | | c. LENGTH OF STAY IN 1b 10 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Annes | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Paul Middle L Last Stevens | | | | 4. DATE OF DEATH Month October Day 6 Year 19 57 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH September 21 1920 37 | |
| 9. AGE (In years lost birthday) 37 yrs. | | IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. | | IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver | | 10b. KIND OF BUSINESS OR INDUSTRY Trucking Company | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Jack Stevens | | | | 14. MOTHER'S MAIDEN NAME Emma | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 0 | | 16. SOCIAL SECURITY NO. 0 | | 17. INFORMANT Hospital records & Mrs Paul Stevens, Rock Hall, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of liver with acute hepatic failure 581.0 DUE TO and/or hepatitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO _____ DUE TO _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 1/2 weeks |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour a. p. Month 19 Day 19 Year 1957 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) October 6, 1957 | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from September 26, 1957 , to September 6, 1957 , that I last saw the deceased alive on October 6, 1957 , and that death occurred at 9:45 P. M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Robert W. Farr | | M.D. Chestertown, Md. | | ADDRESS (Street, city or town, state) Chestertown, Md. | | DATE SIGNED Oct 6, 1957 | |
| PHYSICIAN'S NAME (Type) Robert W. Farr | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 10-9 | | 22c. NAME OF CEMETERY OR CREMATORY Wesley Chapel | | 22d. LOCATION (City, town or county) (State) Rock Hall Ind. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane | | | | 24. REG'D BY REGISTRAR Clara Barnes | | 24b. REGISTRAR'S SIGNATURE Clara Barnes | |

CERTIFICATE OF DEATH

| | | | | | |
|----------------------|--|---------------------------|--|------------------------|--|
| NAME OF DECEASED | | SEX | | AGE | |
| DATE OF DEATH | | PLACE OF DEATH | | CITY | |
| HUSBAND | | WIFE | | CHILD | |
| FATHER | | MOTHER | | SISTER | |
| BROTHER | | Nephew | | Niece | |
| Uncle | | Aunt | | Grandfather | |
| Grandmother | | Great Uncle | | Great Aunt | |
| Cousin | | Stepfather | | Stepmother | |
| Stepson | | Stepdaughter | | Stepbrother | |
| Stepsister | | Foster father | | Foster mother | |
| Foster son | | Foster daughter | | Foster brother | |
| Foster sister | | Adopted | | Other | |
| Cause of Death | | Duration of Illness | | Time of Death | |
| Place of Death | | Name of Physician | | Signature of Physician | |
| Name of Coroner | | Signature of Coroner | | Date of Death | |
| Name of Registrar | | Signature of Registrar | | Date of Registration | |
| Name of Burial Place | | Signature of Burial Place | | Date of Burial | |
| Name of Undertaker | | Signature of Undertaker | | Date of Undertaking | |
| Name of Funeral Home | | Signature of Funeral Home | | Date of Funeral | |
| Name of Cemetery | | Signature of Cemetery | | Date of Interment | |
| Name of Minister | | Signature of Minister | | Date of Service | |
| Name of Musician | | Signature of Musician | | Date of Performance | |
| Name of Flowers | | Signature of Flowers | | Date of Delivery | |
| Name of Food | | Signature of Food | | Date of Delivery | |
| Name of Drink | | Signature of Drink | | Date of Delivery | |
| Name of Other | | Signature of Other | | Date of Delivery | |

BUREAU V. 1

OCT 10 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10772

Reg. Dist. No.

202

10770

| | | | | | | | |
|---|------------------------------------|--|--|--|--|---|--|
| 1. PLACE OF DEATH o. COUNTY KENT MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY KENT | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTERTOWN | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO Millington | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENT + QUEEN HOSPITAL | | | | d. STREET ADDRESS 1 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last PATRICIA MAE WATSON | | | | 4. DATE OF DEATH Month Day Year OCT. 13 1957 | | | |
| 5. SEX F. | 6. COLOR OR RACE Colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 14, 1953 | | 9. AGE (In years lost birthday) 3 yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BABY | | 10b. KIND OF BUSINESS OR INDUSTRY — | | 11. BIRTHPLACE (State or foreign country) MD. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME JAMES H. WATSON | | | | 14. MOTHER'S MAIDEN NAME SARAH JOHNSON | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address SARAH JOHNSON, Millington, MD. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UNKNOWN cause 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Probable overwhlming infection DUE TO (c) Pneumonia & Pleural effusion - | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 DAY | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 10/13 , 19 57 , to 10/13 , 19 57 , that I last saw the deceased alive on 10/13 , 19 57 , and that death occurred at 9:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE Thomas J. Solon | | M.D. Chestertown, Maryland 10/13/57 | | | | | |
| PHYSICIAN'S NAME (Type) THOMAS J. SOLON | | CHESTERTOWN, MD. | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 10/16/57 | | 22c. NAME OF CEMETERY OR CREMATORY RILEY'S NECK, CEM. | | 22d. LOCATION (City, town, or county) (State) MILLINGTON, KENT MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Edward H. Hallowell | | | | ADDRESS Millington, Md. | | 24a. REC'D BY REGISTRAR DATE OCT 21 1957 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Clara B. Bowers | | | |

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | | | | | | | |
|-----------------------|--|-------------------------|--|---------------------|--|-----------------------|--|-------------------|--|-------------------|--|-----------------------|--|----------------------|--|--------------------------|--|--------------------------|--|----------------------------|--|--------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. RACE | | 5. DATE OF BIRTH | | 6. PLACE OF BIRTH | | 7. DATE OF DEATH | | 8. PLACE OF DEATH | | 9. CAUSE OF DEATH | | 10. MANNER OF DEATH | | 11. SIGNATURE OF REGISTRAR | | 12. SIGNATURE OF WITNESS | |
| JAMES EARL RAY | | M | | 35 | | W | | 11/12/21 | | MEMPHIS, TENN. | | 11/12/68 | | MEMPHIS, TENN. | | HEART DISEASE | | NATURAL | | JAMES EARL RAY | | JAMES EARL RAY | |
| 13. DATE OF INTERVIEW | | 14. NAME OF INTERVIEWER | | 15. NAME OF WITNESS | | 16. NAME OF REGISTRAR | | 17. NAME OF CLERK | | 18. NAME OF NURSE | | 19. NAME OF PHYSICIAN | | 20. NAME OF MORTUARY | | 21. NAME OF FUNERAL HOME | | 22. NAME OF BURIAL PLACE | | 23. NAME OF CEMETERY | | 24. NAME OF CHURCH | |
| 11/12/68 | | JAMES EARL RAY | | JAMES EARL RAY | | JAMES EARL RAY | | JAMES EARL RAY | | JAMES EARL RAY | | JAMES EARL RAY | | JAMES EARL RAY | | JAMES EARL RAY | | JAMES EARL RAY | | JAMES EARL RAY | | JAMES EARL RAY | |

BUREAU V. S.

OCT 21 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

202

10771

| | | | | | | | |
|---|----------------------------------|---|--------------------------------------|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Kent MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Kent | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown | | | | c. LENGTH OF STAY IN life | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Pricie Maslin Watson | | | | 4. DATE OF DEATH Month Day Year Oct. 9, 1957 | | | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7/16/1877 | 9. AGE (In years last birthday) 80 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY Housewife | | 11. BIRTHPLACE (State or foreign country) Kent Co. Md. | | 12. CITIZEN OF WHAT COUNTRY? Usa | |
| 13. FATHER'S NAME John Carvil Maslin | | | | 14. MOTHER'S MAIDEN NAME Hannah Ball | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. no | | 17. INFORMANT Address Mrs. Ringgold Strong Chestertown, Md | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery disease, probable infarct 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 481X Influenza | | | | | | INTERVAL BETWEEN ONSET AND DEATH 20 years | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 5-1-57 , 19 57 , to 10-9- 19 57 , that I last saw the deceased alive on 10-9 , 19 57 , and that death occurred at 10:30a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 10-10-57 | | | | | | | |
| ACTUAL SIGNATURE A.C. Dick M.D. | | | | PHYSICIAN'S NAME (Type) A. C. Dick Chestertown, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 10/11/57 | | 22c. NAME OF CEMETERY OR CREMATORY Chester Cemetery | | 22d. LOCATION (City, town, or county) (State) Chestertown, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. Wells ADDRESS Chestertown, Md. | | | | 24a. REC'D BY REGISTRAR DATE 14 1957 | | 24b. REGISTRAR'S SIGNATURE Carol Barnes | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

CERTIFICATE OF DEATH

| | | | | | | | |
|--|---------------------------|--|--------------------------------------|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Kent MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Worton | | | | c. LENGTH OF STAY IN 1b life | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Butlertown | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Edward Middle Whye Last | | | | 4. DATE OF DEATH Month October Day 17 Year 1957 | | | |
| 5. SEX M | 6. COLOR OR RACE C | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec. 25 1886 | | 9. AGE (In years last birthday) 70 yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Kent Co. Md. | |
| 13. FATHER'S NAME William Whye | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 14. MOTHER'S MAIDEN NAME Mollie Dorsey | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. --- | | | | 17. INFORMANT Address Henry C. Whye Worton, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Nephritis 590x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Heart Disease DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 4 months |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from Sept 20 1956 to Sept 17 1957 , that I last saw the deceased alive on Sept 17 1957 , and that death occurred at 5 P. M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE L. P. Atwell | | | | ADDRESS (Street, city or town, state) Still Pond Md. | | | |
| PHYSICIAN'S NAME (Type) L. P. Atwell | | | | DATE SIGNED Oct. 22-57 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Oct. 20, 57 | | 22c. NAME OF CEMETERY OR CREMATORY Butlertown Cemetery | | 22d. LOCATION (City, town, or county) (State) Worton, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams | | | | ADDRESS Chestertown, Md. | | 24a. REC'D BY REGISTRAR Oct. 22-57 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Clara S. Barnes | | | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10776

CERTIFICATE OF DEATH

10775

Reg. Dist. No. 202

| | | | | | | | |
|--|-------------------------------|---|---------------------------------------|---|---|---|--------------------------------|
| 1. PLACE OF DEATH a. COUNTY Kent MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Worton | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Worton | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Muddy Branch Farm | | | | d. STREET ADDRESS / | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Ralph P. Williams Sr. | | | | 4. DATE OF DEATH Month Day Year Oct. 7 1957 | | | |
| 5. SEX M. | 6. COLOR OR RACE W. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 7 1888 | | 9. AGE (In years last birthday) 69 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming | | 10b. KIND OF BUSINESS OR INDUSTRY farm | | 11. BIRTHPLACE (State or foreign country) Worton, Kent Co. Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME George T. Williams | | | | 14. MOTHER'S MAIDEN NAME Sara M tilda Porter | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 220-34-9236 | | 17. INFORMANT Address Sarah C. Williams, Worton, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) coronary insufficiency DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH few minutes | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from November , 19 56 , to Oct. 7 , 19 57 , that I last saw the deceased alive on Oct. 7 , 19 57 , and that death occurred at 5:30 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Robert W. Farr, M. D. CHESTERTOWN, MD. Oct. 8, 1957 | | | | | | | |
| ACTUAL SIGNATURE Robert W. Farr, M. D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Oct. 10, 57 | | 22c. NAME OF CEMETERY OR CREMATORY Still Pond Cem. | | 22d. LOCATION (City, town, or county) (State) Still Pond, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams | | | | ADDRESS Chestertown, Md. | | 24a. REC'D BY REGISTRAR Oct. 10-1957 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Class L. Barnes | | | |

RECEIVED

OCT 14 1957

BUREAU V. E.

CERTIFICATE OF DEATH

MAINTAIN AND STATE DEPARTMENT OF HEALTH - BATHING 18

10777

CERTIFICATE OF DEATH

Reg. Dist. No.

200

| | | | | | | | |
|---|--|----------------------------|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY KENT MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY KENT | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MILLINGTON | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS MILLINGTON x 2 | | | |
| 3. NAME OF DECEASED (Type or print) First LEONARD Middle Wilson Last Wilson | | | | 4. DATE OF DEATH Month OCT. Day 20 Year 1957 | | | |
| 5. SEX M. | | 6. COLOR OR RACE W. | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH MARCH 4, 1875 | |
| 9. AGE (In years last birthday) 82 yrs. | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BANKER | | | | 10b. KIND OF BUSINESS OR INDUSTRY BANK | | 11. BIRTHPLACE (State or foreign country) MD. | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | | | | | |
| 13. FATHER'S NAME EDWARD WILSON | | | | 14. MOTHER'S MAIDEN NAME SARAH GREEN | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | |
| 17. INFORMANT MRS. LEONARD WILSON | | | | Address MILLINGTON, MD. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of the Lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) — DUE TO (c) — INTERVAL BETWEEN ONSET AND DEATH 3 Months | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from Apr. 20, 1957 to Oct. 20, 1957 , that I last saw the deceased alive on Oct. 19, 1957 , and that death occurred at 9 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) MILLINGTON, MD. DATE SIGNED 10.21.57 | | | | | | | |
| ACTUAL SIGNATURE Geza Koralewski | | | | M.D. MILLINGTON, MD. | | | |
| PHYSICIAN'S NAME (Type) GEZA KORALEWSKI | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| BURIAL | | 10/24/57 | | MILLINGTON CEM. | | MILLINGTON, MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Edward Helms | | | | 24a. REC'D BY REGISTRAR DATE OCT 25 1957 | | | |
| ADDRESS MILLINGTON, MD. | | | | 24b. REGISTRAR'S SIGNATURE Thurmond | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

RECEIVED
OCT 23 1957
BUREAU V. 2

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU ONE
CERTIFICATE OF DEATH
1957

NAME OF DECEASED: *John Doe*
AGE: *45*
SEX: *M*
RACE: *W*
DATE OF BIRTH: *1912*
PLACE OF BIRTH: *MASSACHUSETTS*
DATE OF DEATH: *1957*
PLACE OF DEATH: *MASSACHUSETTS*
CAUSE OF DEATH: *Heart Disease*
MANNER OF DEATH: *Natural*
SIGNATURE OF PHYSICIAN: *[Signature]*
SIGNATURE OF REGISTRAR: *[Signature]*